Hospital Letterhead

Hospital ABN 10.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have determined that you no longer require an acute (*hospital inpatient*) level of care. Because your doctor disagreed with this decision we are asking the Quality Improvement Organization _____ (*insert name of QIO*) to review your case.

_____ (*insert name of QIO*) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the Quality Improvement Organization.

Sincerely,

_____
(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)